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DISEASES OF THE NERVOUS SYSTEM

A PRACTICAL JOURNAL ON PSYCHIATRY AND NEUROLOGY

CONTENTS:

SYPHILITIC AMYOTROPHY—Clinical Study of Seven Cases 69
Antonio Gonzalez Revilla, M.D., Baltimore, Maryland

PSYCHIATRIC SOCIAL WORK IN THE AMERICAN RED CROSS 75
Frances Bernhard Weingarten

PETER BASSOE—A Tribute 81
David B. Rotman, M.D., Chicago, Illinois

NEUROLOGICAL CLINICAL PATHOLOGICAL CONFERENCE 85

PSYCHIATRIC ASPECTS OF HEAD INJURY 89
A. E. Bennett, M.D., Omaha, Nebraska

SANITARIA, NEWSNOTES

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DISEASES of the NERVOUS SYSTEM

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A PRACTICAL JOURNAL ON PSYCHIATRY AND NEUROLOGY

Syphilitic Amyotrophy
Clinical Study of Seven Cases*

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Before the advent of the Wassermann reaction, cases of chronic progressive muscular atrophy were usually subjected to antiluetic therapy in the hope that improvement would occur. The fact that such improvement occasionally did result served to fix in the mind of investigators the possibility that syphilis was an important etiological factor in all such cases. It has since been shown that lues is an infrequent cause of progressive muscular atrophy, but the differentiation between syphilitic amyotrophy and the more common amyotrophic lateral sclerosis has received little attention in recent years. It is the purpose of this paper to present certain clinical documents with the idea of stressing the importance of syphilis in the etiology of chronic progressive muscular atrophy, with or without spasticity.

Muscular atrophy in the late stages of tabes dorsalis is a common phenomenon, so common indeed that the atrophic or paralytic stage is spoken of by classical writers[1,2] as the end stage of tabes. We are not so much interested in this aspect of the disease, but rather in the syndromes that may be confused with chronic poliomyelitis, amyotrophic lateral sclerosis, spinal muscular atrophy and peripheral neuropathies of various sorts.[3] While not all cases of muscular atrophy in syphilitics are instances of true syphilitic amyotrophy,[4] nevertheless, the syndrome would seem to be of sufficient frequency to warrant the suspicion that syphilis bears a casual relationship to the muscular wasting unless proved otherwise. The *sine qua non*, however, is the proof of syphilis in the affected individual.[5]

We do not hold with some investigators[6] that an indefinite history of syphilis or of antisyphilitic therapy, or the presence of pleocytosis and hyperalbuminosis of the spinal fluid or other inconclusive evidence of syphilis is sufficient to establish the diagnosis of syphilitic amyotrophy. This limitation may indeed eliminate some cases of probable luetic etiology, since it is well known that a fairly high proportion of cases of tabes and of spastic paraplegia present an entirely negative spinal fluid. In the series of cases studied in the Neurology Service at Gallinger and George Washington University Hospitals there were several additional instances of amyotrophy in which a syphilitic etiology was suspected, but the cases were excluded, and only those retained in which the evidence of syphilis was definite. Unfortunately there is no necropsy material to supplement the clinical studies presented here.

The pathology of syphilitic amyotrophy has excited some controversy since Dejerine[7] published his first reports. This investigator found degeneration of the peripheral nerves which decreased in the vicinity of the spinal

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cord. This finding was corroborated by Hassin.[8] Raymond,[9] however, described degeneration of the ventral horn cells of the spinal cord associated with marginal meningomyelitis, a finding reported by Léri.[10] Perivascular infiltrations have been occasionally described in the meninges, but relatively little of this in the spinal cord. Vascular changes have been more frequently encountered, particularly in the small arteries at the periphery of the spinal cord. Most authors look upon the changes in the anterior horn cells as secondary to involvement of the roots. Descending degeneration in the pyramidal tracts is occasionally observed.[11] If the degeneration is predominant in the dorsal columns, the case is considered primarily tabetic, i.e., radicular, even though there may be extensive muscular wasting.

Clinical Manifestations

The onset is often painful, in contrast to amyotrophic lateral sclerosis which is painless. The muscular atrophy affects more frequently the upper extremities, either the proximal or distal groups, sometimes both, and is strikingly asymmetrical. Fasciculations are usually present but may not be. Reflexes are variable. At times the atrophic muscles give no reflexes; at others the reflexes are increased. Sensory changes are rare unless associated with tabes. However, tingling and numbness may be mentioned by the patients. Spasticity in the lower limbs is often present, thereby giving a rather striking resemblance to amyotrophic lateral sclerosis. But if the atrophy affects the lower limbs, the reflexes may be correspondingly reduced. Asymmetry of reflexes is the rule and the Babinski sign is uncommon. Sphincter and trophic disturbances are usually indicative of more massive changes in the spinal cord. Pupillary reactions usually show some abnormality, sometimes with typical Argyll Robertson findings. Involvement of other cranial nerves is unusual. The course of the disease may be rapid at first with exacerbations and long periods of quiescence, or slowly progressive. Antiluetic treatment may apparently lead to remission in some cases, although improvement is not the rule. When striking improvement occurs following treatment, the diagnosis must be questioned.

CASE REPORTS

Case No. 1

History: R. L., Hosp. No. B36933, colored female, aged 30, admitted June 30, 1941 for progressive weakness of all extremities for two years. The onset of illness was characterized by morning headaches for a month and by pain in the fingers and crawling sensations on the skin of the upper extremities, at times with lightning pains in the right arm. This was followed by weakness in the hands and special difficulty in handling small objects and then by progressive weakness and "jumping" of the right arm. Shortly after, the patient noticed similar progressive weakness of the lower extremities and progressive "wasting" of hands, arms and legs. Six weeks previous to admission she was unable to walk and had occasional urinary incontinence. She gave a history of positive blood Wassermann reaction in 1939, with intermittent bismuth injections.

Examination: The patient was poorly nourished, chronically ill, lying quietly in bed. The general physical examination was negative except for a blood pressure of 170/90. The neurologic examination showed marked weakness in all extremities with moderate atrophy of muscles of arms and thighs, very marked in hands with flattening of the thenar and hypothenar eminences and marked wasting of the interossei, giving the appearance of a claw hand. There were pronounced fasciculations of the tongue, masseters, arms and legs. The deep reflexes were very lively, more so in the lower extremities with a bilaterally positive Babinski sign. The abdominal reflexes were active. There were no sensory disturbances and no cerebellar signs. The pupils were equal and regular, reacting well to light and in accommodation. There was a nasal type of speech, diminished gag reflex and marked atrophy of the tongue. The blood serology and spinal fluid were normal. The course in the hospital was stationary over a period of one year. The patient was given bismuth and iodides, therapeutic malaria ("a few chills," number not specified). She was discharged in about the same condition as on admission and efforts to contact the patient for follow-up studies have been fruitless.

Case No. 2

History: J. D., Hosp. No. B57088, 64 year old, colored male, admitted on August 26, 1942. In February 1942 he began to notice difficulty in using his hands, especially the right one. One month later he complained of stiffness of the legs and also weakness in the left arm; two months afterwards his right leg also became weak. On admission he was unable to lift his arms and could hardly move his feet; he had to remain in bed. He gave a history of nocturnal dull pain in the lower extremities, intermittent in type, but no history of syphilis.

Examination: Patient was undernourished, chronically ill, lying quietly in bed. The general physical examination was negative. The pupils were equal and regular, reacting sluggishly to light and in accommodation. There were tinnitus and reduced air conduction on the right side. Fasciculations of the left side of the tongue were present with suggestive atrophy of the same side. Pronounced fasciculations were also present over the chest, thighs and legs. The arms were lying feebly, pronated, whereas the lower extremities were relaxed and in external rotation. Generalized atrophy was present in the muscles of the extremities, neck and trunk with the exception of the abdominals and pelvic girdle. There was pronounced flattening of thenar and hypothenar eminences bilaterally. The pectorals were similarly atrophied with gross fasciculation in both sides. The atrophy in the lower extremities was more pronounced in the flexors of thighs and calves. Skilled movements in all extremities were extremely limited. There were certain sensory changes: diminished light touch over dorsum of both feet, more so on the right; impaired vibratory sensibility of right foot; two-points discrimination very poor all over the body, especially on trunk and lower limbs; no nerve or muscular tenderness, positive Abadie sign bilaterally. Deep reflexes were absent in the upper extremities and extremely hypoactive in the lower. Positive Chaddock and negative Babinski. Cerebrospinal fluid showed a normal pressure and normal dynamics; there were no cells; 40 mgs. of proteins per 100 cc.; positive Kahn; colloidal gold: 1111100000. Blood serology was negative. No anti-luetic treatment was given. Therapy was restricted to high doses of Vitamin B complex. The patient remained in a stationary condition for many months and ultimately was transferred to Blue Plains Home for the Aged where he died on April 3, 1943. Permission for necropsy was not granted.

Case No. 3

History: R. T., Hosp. No. B83407, 64 year old colored male admitted March 1, 1944. For eight or nine years before admission patient had been noticing a progressive degree of weakness in both hands. About 5 or 6 years previously he began to notice a slight degree of weakness of his legs. However, he had been able to walk and did not think that the weakness of his legs had progressed very much. No history of pain. One month before entering the hospital the patient struck a nail in the ball of his right foot. It did not bother him until one week later at which time he sought treatment at another hospital. The condition of the foot gradually became worse so that he was admitted to the surgical service where we saw him on consultation. He did not give history of syphilis or diabetes.

Examination: Well-developed, well-nourished colored male who was not seriously ill. There was slight exophthalmos bilaterally. All the teeth were missing. Heart and lungs were essentially normal. Nothing abnormal was found in abdomen or external genitalia. The right foot was edematous, displaying an area of bluish black discoloration extending from the base of first and second metatarsals to phalanges of first and second toes; there was slight excoriation of this area and some tenderness. Blood pressure was 170/96. The neurologic examination revealed the following pertinent facts: there was slight bilateral exophthalmos; the right pupil was irregular and smaller than the left, both reacting well to light and in accommodation. Right eyeball deviated to the right but the extraocular movements were not limited. Moderate ptosis of right eyelid. Hearing was reduced by otosclerosis. There was no atrophy or fasciculation of the tongue. There was marked atrophy of interossei and lumbricales of both hands with moderate atrophy of thenar and hypothenar eminences bilaterally. Suggestive atrophy and definite flabbiness of biceps and triceps bilaterally, and of all muscles of both thighs and interossei of left foot. Marked weakness of extensors and abductors of the thighs. Coarse fasciculations were present in the left peroneal group of muscles. Sensory changes were limited to the lower extremities: moderate impairment to thermal stimuli on sole of both feet and tips of the toes; absent vibratory sensibility from the hips down bilaterally. Deep reflexes were markedly diminished throughout. Mayer's sign was absent on the right and present on the left. Abdominal reflexes were absent bilaterally, and cremasteric on the right. The Babinski sign was positive on the left. The spinal fluid revealed a normal pressure with normal dynamics; cell count of 6 lymphocytes per c.mm; positive Kahn and a colloidal gold curve of 0001210000. Blood Kahn was 4 plus. Fasting blood sugar 280 mgs. per 100 cc. The patient died two months later of gas gengrene after a right supracondylar amputation was performed. Permission for necropsy was not granted.

Case No. 4

History: A. S., Hosp. No. B78288, colored male, aged 56, admitted November 21, 1943. Patient worked until the day of admission. While coming home from work he experienced a sudden numbness with extreme tingling, very similar to an electric shock, in the fingers of both hands. This radiated to the wrists. It was of such intensity at the onset that the patient fell to the ground even though his feet were not involved and there was no unconsciousness or impairment of his senses. The paraesthesias continued unabated until hospital admission. There was no history of trauma and the patient was in perfect health as far as he knew. He gave a history of brief anti-luetic therapy in 1943. He consumed about 1½ pints of whisky daily while claiming to eat three fairly well balanced meals every day.

Examination: General physical examination was negative. The cranial nerves were normal

except for slight irregularity of the left pupil, both reacting well to light and in accommodation; twitching of both masseters in clenching teeth; moderate atrophy of the right side of the tongue with fine fasciculations on both sides. Triceps, biceps, deltoid, brachio-radialis and extensor carpi radialis longus on both sides showed muscular twitchings at rest and during reinforcement. Both triceps and biceps showed slight degree of atrophy, the left biceps more than the right. Moderate flattening of thenar and hypothenar eminences more so in the right. Diminution of power in both arms and slower speed in the right. Slight intention tremor on right on the finger-to-finger test. No changes were noted in the muscles of the thorax, abdomen and lower extremities. Sensation was unimpaired throughout, except for reduced pain on pressure over Achilles tendon bilaterally. Deep reflexes were as follows: Triceps absent on the right, active on the left; biceps absent bilaterally; radial and ulnar diminished bilaterally; patellars and Achilles equally active. The upper abdominals were markedly diminished and the lower were absent. Cremasterics absent. Babinski negative. Blood Kahn was 3 plus. Spinal fluid with normal pressure and dynamics; 3 lymphocytes; gold curve of 1112210000 and a negative Kahn. While at the hospital the patient was treated with ten intravenous injections of mapharsen 0.06 gm. every fifth day, 30 mgs. of thiamin chloride daily, and 90 mgs. of vitamin E during the first week, which was later discontinued in order to observe the effect of the anti-luetic treatment alone. On discharge, February 14, 1944, the patient was somewhat improved. There was considerable return of power in the upper extremities; fasciculations were still present but markedly diminished, with no changes in the deep reflexes. At present the patient is under anti-luetic treatment, working, and has had no progress of his neurologic signs.

Case No. 5

History: F. B., Hosp. No. B81/50, colored male, aged 52, admitted on January 31, 1944. Patient was in good health in September 1943, working steadily with no complaints. The following month he began to have difficulty in putting on his shirt because of some pain in his right shoulder whenever he tried to move his arm. Later on, his left arm and leg became difficult to control. Weakness increased so that he had trouble in buttoning his clothes or tying his shoes. Difficulty in walking developed rapidly a week before admission. He also gave a history of a "cold" for the past two months, with an unusually "bad cough" for two days before admission. The Wassermann reaction was positive.

Examination: The patient was extremely emaciated. The general physical examination revealed dullness in the postero-inferior part of right hemithorax and on auscultation a large area of tubular breathing was found over the same area, with crepitant and subcrepitant rales over the right infraclavicular region. Furthermore, there was evidence of chronic hypertrophic osteoarthropathy with clubbed finger tips and spoon finger nails. The neurologic examination disclosed the following positive findings: the pupils were equal but irregular, reacting well to light and distance. Bilateral anosmia. Moderate concentric constriction of visual fields, with impaired visual acuity. Poor tonus of masseters and pterygoids bilaterally with inability to move the mandible from side to side. Diminished air conduction on left. Moderate atrophy of sternomastoids and trapezii bilaterally. Coarse fasciculations of the tongue with no atrophy or deviation. Marked atrophy of the scapulo-humeral group of muscles bilaterally with occasional visible fasciculations of biceps. Atrophy of muscles of both forearms. Fasciculations of small muscles of both hands with no atrophy. Patient could not raise right arm above horizontal, adduction of same arm being difficult and painful; adbuction was unimpaired. Movements with left arm were limited but not as pronounced limitation as in the right. He could not sit up in bed alone but could roll over unaided. In the lower extremities there was some weakness of the right quadriceps femoris, the left leg was unaffected. All forms of sensation were normal. Deep reflexes were markedly diminished in the upper extremities and quite active in the lower. Absent abdominals and cremasterics. Babinski questionable on the left. Blood Kahn 4 plus. Spinal fluid with normal pressure and dynamics; no cells; 20 mgs. of proteins per 100 cc.; negative Kahn and a colloidal gold curve of 0011000000. X-ray of the chest revealed dense infiltration in lower two thirds of the right lung suggesting the presence of pneumonia. Sputum for acid-fast bacilli was consistently negative. In spite of chest changes the temperature never rose over 101. Sulfamerazine was given for eleven consecutive days at the end of which a second x-ray film of the chest was reported as negative. A muscle biopsy was done in this case and the report read as follows: "Specimen consists of muscle tissue of extreme variability in size, some of the fibers being quite swollen and more or less granular or striated and others being very small and atrophic, surrounded by an increased number of perimysial nuclei and showing obvious indications of degeneration. There is little increase in the connective tissue and the blood vessels seem unaffected." The patient was given bismuth intramuscularly and was discharged two months later subjectively better with no changes in the neurologic status. He was referred to the anti-luetic clinic for treatment. No report since.

Case No. 6

History: C. P., Hosp. No. B96334, aged 39, colored female, admitted October 25, 1944 in a drowsy state with the history of the onset of her illness in August 1944 when she started to complain of overall weakness and severe, inter-

mittent, generalized headaches. At the same time she complained of increasing weakness of the left hand which became stationary about the middle of September. One month previous to admission the headaches increased in severity and at times were accompanied by projectile vomiting. These symptoms progressed gradually so that one week before her entrance to the hospital she was bed ridden. The day of admission she became irrational and drowsy. No history of syphilis could be obtained.

Examination: Patient was somewhat emaciated, drowsy and complaining of severe headache. Pulse, 92; temperature, 102.8 F; respiration, 30 and blood pressure 120/72. The physical examination was negative. The neurologic examination revealed moderate rigidity of the neck with bilateral Kernig. The cranial nerves were essentially normal except for slight irregularity of both pupils which reacted sluggishly to light. There was moderate weakness of the left hand grip and also in abducting the left arm. The left thenar and hypothenar eminences were markedly flattened but there were no visible fasciculations. Coordination was good in all extremities and sensation was unimpaired throughout. The deep reflexes were equally diminished in the upper extremities and normal in the lower. The abdominals were active and there were no abnormal superficial reflexes. Cerebrospinal fluid showed a normal pressure and normal dynamics; there were 530 white cells per cu.mm. all lymphocytes; proteins, 112 mgs. per 100 cc.; Wassermann weakly positive and a colloidal gold of 5443332100. Studies were positive for the virus of choriomeningitis. Blood Kahn was three plus. In less than a week the patient recuperated from her meningeal symptoms and intramuscular injections of bismuth were commenced. Undoubtedly in this patient there are two diseases superimposed on each other: the luetic amyotrophy which started in August, being characterized by weakness of the left hand, and the choriomeningitis which started one month later from which she recuperated spontaneously.

Case No. 7

History: G.S., Hosp. No. B97118, aged 74, white male, admitted November 11, 1944. Three months previous to admission he started to complain of numbness and tingling in soles of both feet associated with difficulty in walking. These symptoms progressed so rapidly that on admission the patient was bed ridden. He gave no history of sphincter difficulties. He gave a history of a positive blood Wassermann in 1918 with treatment consisting of two intravenous injections weekly for a period of three months.

Examination: Patient was a well-neurished elderly white male appearing chronically ill. The blood pressure was 176/94. There were varicose veins in both lower extremities. The pupils were equal but irregular, reacting well to light and distance. The fundi were normal. The right corneal reflex was absent. Bone conduction was greater than air conduction on the right. There was suggestive atrophy of the right side of the tongue with gross fasciculations on the left. The palatal and pharyngeal reflexes were absent. There was marked weakness in the hand grip and in abduction of the arms bilaterally. Weakness was also present in extensors of both thighs. There were coarse fasciculations in the scapular muscles, deltoids, biceps, triceps, pectorals and peroneals. Both deltoids were moderately atrophied, the atrophy being more pronounced on the left. The biceps were flabby with definite atrophy on the left. Slight flattening of both thenar eminences bilaterally. Extensors of both thighs were flabby. Sensation was unimpaired in the upper extremities. Vibratory sensibility was absent from the 10th dorsal vertebra to the tips of the toes bilaterally. Deep reflexes were hyperactive in the upper extremities; patellars were equally active and both Achilles were absent. Bilateral Hoffmann and negative Babinski bilaterally. The cerebrospinal fluid showed normal pressure and normal dynamics; proteins, 51 mgs.; no cells; negative Kahn and a negative colloidal gold curve. Blood Wasserman was three plus. The patient improved but slightly under treatment by bismuth and iodides.

COMMENT

It will be noted that six of the seven patients were negroes. Cases 1, 3 and 7 gave a history of inadequate anti-luetic therapy and the other four denied any history of lues or previous treatment. In cases 1, 2, 3 and 7 the onset was characterized by pain: in case 3 pain was localized in both hands and of such an intensity that the patient fell to the ground. Fasciculations were present in all but Case 6. The muscular atrophy was patchy and irregular, being more pronounced in the upper extremities, four of them taking the distribution of Aran-Duchenne. The deep reflexes were hyper-active in two of the cases and markedly diminished or absent in the rest. There were other signs of pyramidal tract involvement in six cases. No sensory disturbances were noted in Cases 4, 5 and 6: in Case 2 there was diminished light touch over dorsum of both feet, impaired vibratory sensibility on right foot, impairment of two-points discrimination all over the body, especially over trunk and lower limbs; in Case 3 there was moderate impairment to thermal stimuli on soles of both feet and tips of toes and absent vibratory sensibility from the hips down; vibration was also absent in Case 7 from the tenth dorsal vertebra to the tips

of all the toes bilaterally. Pupillary abnormalities were found in six cases but no true Argyll Robertson pupil was observed in any of them. Fasciculation of masseters was present in Case 1 and Cases 1 and 5. There were varying degrees of involvement of the tongue in five of the cases. Urinary incontinence was present in Case 1.

The blood and cerebrospinal fluid were negative in Case 1, but there was definite history of a previous positive blood and unsatisfactory therapy; in Case 2 the blood was normal but the spinal fluid was positive. In Cases 3 and 6 both blood and cerebrospinal fluid were positive and in Cases 4, 5 and 7 the blood serology was positive whereas the cerebrospinal fluid was negative. It is noteworthy that in only one of our cases was there a significant pleocytosis in the cerebrospinal fluid. That was in Case 6 where the increased cell count was due to the concomittant choriomeningitis and not to the luetic process.

In one case there was objective improvement after two months of anti-luetic therapy and in another there was merely subjective improvement. One patient died from an intercurrent disease nine years after the onset of the amyotrophy. Case 2 had no treatment and died 14 months after the appearance of the first symptoms. In another one there was no improvement in spite of intensive treatment. Cases 6 and 7 have just started treatment.

SUMMARY

1. Luetic amyotrophy although uncommon is not a rarity.
2. The pathogenesis may consist in arteritis of the intraspinal vessels, but in many cases a leptomeningitis with marginal degeneration of the white matter of the cord and retrograde degeneration of the anterior horn cells may be present. The pyramidal tracts may or may not be affected.
3. The differential diagnosis is difficult but we should bear in mind the following pertinent facts:
   (a) In the majority of cases a luetic history is wanting.
   (b) The muscular atrophy does not follow the classical pattern but is characterized by a patchy and irregular distribution.
   (c) Deep reflexes are usually diminished or absent, but there are instances in which they are hyperactive.
   (d) Cranial nerves abnormalities, sensory and sphincter disturbances may or may not be present. The involvement of the tongue is less frequent in other reports.
   (e) Either the blood or the spinal fluid should be positive: if both are negative there should be at least a history of a positive serology and anti-luetic therapy.
4. As reported in the literature, intensive anti-luetic therapy in its early stage may arrest the disease.
5. Luetic amyotrophy tends to run a longer and more intermittent course than the idiopathic type, although there are instances in which the course is progressive.

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Psychiatric Social Work in the American Red Cross

FRANCES BERNHARD WEINGARTEN*

It began in 1918 when the military requested Red Cross medical and psychiatric social workers and then recreation workers be added to their hospitals. During this war the number of workers grew and the scope of their work increased markedly. With the cessation of hostilities and the gradual lessening of emergency war pressures, the American Red Cross hospital staffs are now beginning to find time to study and analyze their services to neuropsychiatric patients in order to establish the highest possible standards in the ongoing peacetime program.

In the ARC program prior to this war, ARC psychiatric social workers were assigned to all military hospitals having a psychiatrist. At the request of the military during the war, the assignment of ARC psychiatric social workers grew with the establishment and expansion of all types of Army and Navy installations caring for NP patients. Some developments were psychiatric units of Naval Training Stations, Consultation Services (Mental Hygiene Units) and the NP Reconditioning program of the Army. After Pearl Harbor the ARC went wherever the Army went overseas. Social workers worked in Army Psychiatric Centers, sometimes in general hospitals, sometimes in field hospitals and on hospital ships carrying NP patients.

It was evident from the beginning that the number of persons professionally qualified in casework with neuropsychiatric patients, as in the other fields of social case work, was far below the number needed. In consequence the American Red Cross filled in the gaps as far as possible by assigning generic case workers and women of suitable personality who had little or no social work background to work with psychoneurotics, utilizing various types of in-service training to afford them some degree of understanding of the behavior and needs of the patients. This was done with the concurrence of Army and Navy officials, and military psychiatrists assisted with several training projects conducted in hospitals.

The case work processes of Red Cross PSWs are basically the same as those used in any social case situation adapted to the military and Red Cross settings. The fact that the Red Cross workers are women, and civilians, has been recognized throughout the history of this program as an asset in dealing with patients who experience a lessening of restraint, and a sense of renewal of contact with their previously accustomed environment, from the contact. This is significant aid in developing that most important tool of casework in all settings, a relationship with the patient. Overseas workers found that even a limited relationship (because of numbers, lack of time, etc.) was often useful to the emotionally disturbed patient in gaining some control of his conflicting feelings of fear or doubt, might increase his understanding of reality as well as understanding of his illness so that he could begin to plan within it. We use the casework relationship in many ways; sometimes to give the patient emotional support through a trying period, sometimes through manipulation of the military and/or home environment to relieve strains affecting the patient. Sometimes we can use it to help the patient gain insight into the sources of the problems that he brings to us so that he can solve them. Lastly, we use it to help the patient formulate plans around return to duty, or to further hospitalization, or to return to the community. This post-discharge planning depends on close cooperation of hospital social worker and community Red Cross Chapter. Red Cross social workers serving NP patients also have certain military prescribed Red Cross functions similar to those throughout the Red Cross hospital program, such as: personal services, financial assistance, health and welfare reports regarding patients or families, and help with other personal or family problems.

Workers' experiences emphasized the value of release gained by patients who talked over

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recent traumatic war experiences with them. One psychiatric social worker in the ETO was attached to the Division Psychiatrist of an Infantry Division. This social work assignment was relatively unique. Men with emotional problems were referred to her primarily for social histories and occasionally for interviews. Among those she saw were men who went on sick call repeatedly, complaining of vague symptoms, headaches, backaches, etc. Doctors who had been unable to help them medically would refer them to the psychiatrist. One man was hospitalized for a stomach complaint that sounded much like "ulcers" but this was unsupported by diagnostic tests. He returned to duty after hospitalization still complaining of the same symptoms. When he was unable to carry out his duties, he was referred for psychiatric help. During the psychiatric history interview the social worker found him to be feeling bitter, discouraged and frightened. He felt that because the medical officers had been unable to cure him, medical science, the Army, and his country that had promised him so much care, had failed him. This military setting, in a war zone, did not permit changes in environment to relieve strains. The army orders were "No leaves, no transfers, no hospitalization except in extreme emergencies." Hence the social worker was put to the test to integrate all her professional knowledge and skill to help this man adapt to the environment. The military considered such social histories taken by the ARC worker indispensable for it often provided diagnostic clues, saved the psychiatrist valuable time for treatment, and served to select patients who would most benefit from psychotherapeutic interviews with the psychiatrist or supportive interviews with the social worker. In domestic hospitals social histories required by the military in evaluation of the NP patient could often be supplemented by information from the family and other sources secured by the local Red Cross chapter. In some hospitals chiefs of medical services referred patients directly to the psychiatric social worker for a social and personality study as a basis for determining referral to the psychiatrist. Overseas the case worker continues to be challenged as the picture changes. Military units are growing smaller and patients are no longer battle casualties. Occupation and garrison troops are living under conditions particularly conducive to nervous tensions. Psychiatric treatment will need to be geared to enable men to return to duty whenever possible.

The following cases were chosen from the field to illustrate Red Cross casework with mentally or emotionally disturbed patients in some military settings. Each worker's ability to help the patient was limited by her knowledge, her skill in adapting her casework to the military, to military psychiatry and to constantly changing pressures. They were chosen to show variety of problems rather than to demonstrate good casework practice.

Case I: Time limitations led the hospital team to try new techniques in this case. The casework planning for Sgt. R and Pvt. S was accomplished by the psychiatrist, who was used as a consultant by the surgical medical officer, and Miss M the social worker. Sgt. R was a depressed patient on the psychiatric ward and Pvt. S a surgical case and bitter. Sgt. R had been a fine pianist before the war but was afraid to play, fearing his own inadequacy. Pvt. S was 21 and had had three fingers amputated on his left hand. His hand was getting along fine and could be used for many purposes but Pvt. S was taking it hard and withdrew into himself. The psychiatrist recommended a plan for Sgt. R which if successful would be a short-cut in therapy. With the cooperation of the Red Cross recreation worker, a piano was delivered to the NP ward. It was seized upon by a group of enthusiastic patients and "boogie-woogie" reigned. Sgt. R sat and glared, then retreated to his room where he cursed violently and paced the floor. The "downbeat" boys held the fort for several days, until another patient who shared Sgt. R's loathing burst out in Miss M's presence, "For God's sake, can't anyone around here play music?" Miss M remarked, "Why I believe Sgt. R could if he would." Sgt. R colored furiously, "All out of practice; can't play a thing." The other patient eyed him severely, "Look, brother, I don't care how bad it is, somebody has to sit at that piano, if you don't, they will." Sgt. R allowed himself to be pushed on the stool. His fingers found familiar cords. The playing continued as the days passed.

Meanwhile on the surgical ward, Pvt. S was

silent and unresponsive in interviews with the psychiatrist and later with Miss M. Only regarding his future training and employment would he talk. All shared the feeling that his hands had been very important. They decided to ask Sgt. R to participate in a birthday party for Pvt. S — cakes, candles, flowers, music and fun.

On the recommendation of the psychiatrist, Miss M told something of Pvt. S's story to Sgt. R and asked for his aid. He was hesitant. Encouraged to come along and see for himself how much Pvt. S needed help and how he might participate, he accompanied Miss M to the surgical ward. The two patients met, later Sgt. R commented that he would be glad to play for Pvt. S's party. To him Pvt. S "looked as sunk" as he himself had felt not long before.

Cheers greeted the lighted birthday cake atop the Red Cross piano as it rolled into the surgical ward propelled by Sgt. R. In front of Pvt. S's bed the piano was halted and Sgt. R played "Happy Birthday to You." Every patient on the ward joined in. Miss M and the psychiatrist, sharing in the festivity saw that the 21 year old Pvt. S was very tense. At the piano Sgt. R seemed hesitant, but finally said to the private that if he named a selection he would try to play it —it was his party.

It seemed to cost Pvt. S great effort to speak but he managed to say, "Beethoven."

As the symphony ended, Pvt. S's forehead was moist and his eyes were brilliant. He turned to Miss M: "You asked me what I did before I came into the Army—I played the organ."

Sgt. R caught that last phrase and immediately he was standing over Pvt. S. His words were quiet but stern. He tore into Pvt. S. "Music is more than playing—it is knowledge, understanding, appreciation. Losing three fingers can't change any of that." With this he whirled back to the piano and into a fury of music.

Pvt. S slowly relaxed and for an hour, with thirty other patients speechless with excitement and pleasure, he listened.

The next day, Sgt. R came to RC to ask if he could take the piano to the surgical ward. This became routine until one day both he and the Pvt. appeared to ask if they could take that piano and another one to the NP ward—they needed two. The Pvt. had pointedly told Sgt. R that he could make more music with one hand than the Sgt. could with two. The friendly battle was on. Later, both pianos were moved into the Red Cross recreation room, as a scene for spectators at their duels. Within a few days' time, from the Red Cross auditorium came such music as is rarely heard. Two men played for themselves and for each other while the auditorium filled with patients, unnoticed by the players—as unnoticed as the fact that only a few weeks before Sgt. R had been "afraid" to play—as unnoticed as the fact that from one piano came a two-fingered bass, played by fingers that had forgotten three of their number were missing.

Case II: A Red Cross social worker in the South Pacific became concerned about a pilot whose plane had been shot down. On his release from a Japanese prison camp he found that his family had been notified of his presumed death. In the hospital he seemed withdrawn and silent. He slept a great deal and was completely unresponsive during the first half of his two weeks stay. The morning after his admission he had asked the social worker to send a commercial cable to his mother requesting news of his family. He chose to give an Army Base APO instead of the hospital address and did not respond when the worker told him the Red Cross would be glad to cable for him. He waited in vain four days for a reply, then returned to ask the worker to send a Red Cross cable. He showed no interest when told that it was possible to telephone his family. Days later and with much hesitation, he came to the worker to confess that he wasn't sure he still had a family. At the time of his capture he was married and had a daughter. He showed the worker a copy of a cable that the man who had been his gunner had received. When the gunner was released from prison he learned that his wife had remarried, believing him dead. The pilot had experienced such shock from the gunners' experience that he had feared to make contact with his own family lest he find that his wife too had entered upon another marriage. With the worker's help the pilot finally decided to telephone home "to talk to mother." Fortunately the

call gave him the chance to talk to all three of his women folk and from the time he knew he "still had a family" he changed. He never became talkative, but became more outgoing and showed his enjoyment of the social worker's visits. He requested her to buy stamps so he could write to his restored family; she was asked to shop for hair brushes, she helped him choose gifts to take home. When the reply came to the Red Cross cable, he grinned so widely he couldn't have talked . . . . his wife and daughter were on their way to San Francisco to meet him!

Case III: This is an instance of preventive social work where a man was able to continue with his duties after receiving casework help. The sailor was depressed, nervous and worried about his home situation when he was referred to a psychiatric unit of a Naval Training Station for examination and treatment. The Red Cross PSW in an interview with him learned the social history facts and then the psychiatrist asked the worker to assist the sailor with his personal problems. He had moved his wife and child to California when he was stationed there so that they could see each other often in the hope that this would improve the "nervous condition" from which his wife suffered. When he was transferred his wife's letters told of her increasing depression and the sailor grew worried. After consultation with the psychiatrist the worker asked the California Red Cross Chapter to interview the wife and arrange for her to be seen in a psychiatric clinic in order to ascertain her mental condition. With the consent of the sailor, a social history from his family and a medical report from his wife's doctor was secured by the local Red Cross chapter. The psychiatric report stated that his wife was depressed, suicidal, and recommended her hospitalization. The psychiatric social worker gave the seaman some interpretation of his wife's mental illness and the Navy granted him an emergency leave to go home and make plans for his wife. He explained on his return that he had been unable to bring himself to hospitalize his wife as she opposed this. After talking with the Red Cross chapter worker he again had his wife placed under psychiatric treatment.

The social history showed that the sailor had made an adequate life adjustment formerly. In interviews with the clinic social worker, the sailor began to realize that his own nervousness was due to worry over his wife and not to any inner personal inadequacy. It was planned that the Red Cross Chapter continue visiting the wife in order to assist with emergency hospitalization should it be required. At the sailor's request the chapter worker was also asked to give some interpretation to his wife of his inability to get a discharge, that he was needed in the Navy. The seaman returned to duty and was able to perform his duties knowing that the Red Cross would help in his absence.

Case IV: Planning around an NP patient's discharge from the Army is another important service rendered by the social worker.

Pvt. J, age 24 was the only child of a wealthy family. He had a B.A. degree in journalism but his only job prior to his army induction as a part time clerk was secured for him by his father. This job was incompatible with his I.Q. and educational training. Pvt. J had always been clumsy, stuttered, was somewhat seclusive and shy. He had a marked sexual maladjustment that probably represented a dynamic regression. All his contacts were with prostitutes and he was usually impotent. Like his mother and maternal grandparents he had suffered from asthmatic attacks in civilian life. He had headaches during college, thought to have been of neurotic origin by his physician. Following army induction and basic training, Pvt. J was sent to the ETO and went to France on D-Day, performing a laborer's duties. He griped continually, threatened suicide and was censured by the men in his outfit. Another soldier induced him to see a medical officer and he was evacuated. On an LST he cut both wrists with a razor and later in a hospital in the states he made another suicidal attempt but the cuts were superficial lacerations. On entering the Army NP Hospital in the United States he was circumstantial, ver. se. cynical and preoccupied with ideas of h vn inadequacy. The Medical Board thoug . he had had a schizophrenic episode and that his great emphasis upon inadequacy was in the character of a grandiose delusion. They recommended his discharge in the care of his family. The patient's parents had always been

hostile to each other and had been divorced six years earlier. This posed a problem for the psychiatric social worker.

The social and medical diagnoses of Pvt. J were used by the team of psychiatrist and case worker in working out post discharge plans with the patient and his family who visited the hospital. The medical officer undertook most of the interpretation of the patient's illness to his family in an authoritative manner, since time was limited and at first their hostility towards the Army dominated their concern for their son's welfare. Sometimes the parents were seen together by both the psychiatrist and/or the social worker, sometimes individually. During the social history interview the patient asked the worker for regular interviews. These were held once a week only due to Pvt. J's limited insight but there were almost daily short ward contacts. Case work with him was directed towards interpretation of the hospital and joint planning regarding his future. As the interviews continued, Pvt. J's plans became more realistic and he became less demanding on the ward. At first neither the patient nor his family considered medical treatment necessary after discharge. The medical officer again played an authoritative role in giving recommendations for further psychiatric care. The case worker used the strong emotions this evoked in the parents to effect a more rapid transition in their thinking regarding the patient's future.

The mother, who was originally protective of the patient in interviews with the social worker, began to express her indentification with him and her own feelings of inadequacy which were in many ways similar to his, but more realistic. She thought the father had always over-disciplined Pvt. J and demanded too much of him. She remained rather passive but gradually gave some support and encouragement to the patient. The father had remarried but felt responsibility for Pvt. J in terms of getting him a job and helping with money. At first he wished to purchase a newspaper which the patient would operate. As he grew in understanding of the patient's illness, his guarded prognosis, his limitations and abilities, the father was able to be less authoritative with the patient and his former wife, and to make plans with them instead of telling them what to do. His great grief in having an inadequate son with whom he could not identify emerged but this was paralleled by his seeing his responsibility to this son in new ways. He secured a job as copy writer for Pvt. J where he could work with someone who would give understanding supervision and where pressures could be modified to suit his needs. This job was directly in line with the patient's interest in writing. They decided that Pvt. J would live with his mother but would see his father frequently. Upon his discharge from the Army the patient and his family were referred for further help to the local Red Cross chapter who were fully informed of the situation with the consent of all concerned. It was learned later that the patient had started intensive treatment with a psychoanalyst and was getting along well enough in his job and at home to continue to live in the community.

From the point of view of the case worker, it may be added Red Cross service in military hospitals affords an opportunity to work with a cross section of the young adult population, irrespective of economic status, which is seldom experienced elsewhere.

Recently two psychiatrists described their experiences with social workers in military NP settings. One had recently returned to civilian practice and he found himself greatly handicapped by lack of case work service for his patients whom he described as belonging to the middle class. The other, anticipating his release from the Army, recognized that he too would be leaving behind the social work facilities of the military setting which he now considered indispensable. It is fitting that social workers in the military program had their share in the most important social experience of this generation. Now we must take part in the peace in a time of unrest and change. Whatever plans develop regarding military conscription or a unified command for Army and Navy, social workers in the American Red Cross have the responsibility of analyzing their work and the trends that may affect it so that the continuing hospital program will provide a better quality of service to every patient in need of help. For the most part it is too early to make predictions, but let us share with you our

thinking and concerns for the future regarding some aspects of the Red Cross hospital program.

The ARC has recreation workers on its staffs in most overseas and domestic hospitals. At the request of medical officers they are taking part in activities on the NP wards. The social worker with psychiatric training has been challenged to share her understanding of patients with the recreation worker and together they have found new ways of carrying out joint responsibilities. We anticipate a desire on the part of officers to use recreation more intensively in their treatment plans for patients. Integration of the service of ARC social workers and recreation workers is growing in military hospitals as a phase of the Red Cross program there. It seems probable that civilian hospitals also may find it useful to combine casework and recreation for patients.

The dearth of professionally qualified personnel will still beset the ARC along with other agencies. Overseas the Red Cross social work program in the hospitals serving occupation troops and garrison forces will continue the current adaptation to the needs of men experiencing the tension incident to occupation duty in territory belonging to a conquered foe, and experienced, well trained workers in adequate numbers will be required. The established standards of medical and psychiatric social work in military hospitals are the measuring rods used by the Red Cross in evaluating its work in military hospitals. Realizing that the need for trained workers will exceed the number available, Red Cross, in order to secure well qualified personnel in adequate numbers, will probably need to continue to supplement the work of psychiatric social workers on its staffs by utilizing persons with basic social work skills, giving some in-service training in psychiatric social work.

In army life the group rather than the family is of primary importance. In the wartime military hospitals social workers sometimes found it expedient to use a group approach directed toward treatment of patients with mental or emotional illnesses. Usually these group methods were not deliberately instituted, but grew informally out of discussions of patients living together on wards, patients who shared many common experiences and concerns. Reports from many workers indicate an awareness of the value of group responses. This may be a field psychiatric social workers will want to explore further. We should expect continued military improvement of screening processes developed in the war and hope that the trend towards psychiatric preventive work, such as that done in psychiatric units in Naval Training Stations and in the Army Consultation Services, will continue. Perhaps it will include orientation of all types of military personnel, including non-medical, in the meaning of behavior. This might lead to expansion of psychiatric facilities designed to help patients not in need of hospitalization and more intensive psychiatric treatment within the military setting. In any case, development of areas of responsibility for each member of the psychiatric team must be explored. As there is more widespread military use of medical officers trained in psychiatry we anticipate as a corollary an increased need for psychiatric social workers. The growing awareness of psychosomatic mechanisms in illness by the medical profession will probably mean increased utilization of the psychiatrist in a consultative capacity by other physicians. The psychiatrist's work might then be supplemented by increased use of the skills of psychiatric social workers and recreation workers in order for the psychiatrist to better evaluate and treat the patient.

Psychiatric social workers are found in a wide variety of military settings. Their work receives more acceptance and understanding than ever before from the other members of the professional team. Many patients and many military personnel will take this understanding with them to civilian life. The development and growth of the psychiatric program in a military setting is evidence of the practicality of being aware of individual emotional needs, particularly as they affect the person's performance and consequent usefulness. Therefore as the military program continues with new emphasis and directions, whatever participation Red Cross hospital service is privileged to have in the future will, as in the past, enrich the experience of psychiatric social work.

Peter Bassoe

A Tribute

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Somewhere in Longfellow there is a line which reads, "sing me from the lesser bards." Translated into the language of our day, it can be read to mean that sometimes it is profitable to lend an ear to the words of the smaller fry. The death of Dr. Bassoe has struck a profound note of sadness throughout the neuropsychiatric world. A fitting memorial has already been held in the library of Rush Medical College, within whose walls his major labors had been consummated. Official and proper note of his passing has been and is being made in the leading neurological and psychiatric journals. All of these eulogies have come from persons either his senior in years or from his neuropsychiatric peers. I believe the picture would be incomplete without some word from one of the younger men who have worked under the guidance of Dr. Bassoe. It is in this humble spirit that I submit these few words. I know of no one who feels himself more indebted to him for that guidance and beneficence than myself.

The day that I met Dr. Bassoe shall remain forever a red letter one in my life. The time was World War I. It was a midsummer's day in 1918; the site was Camp Taylor, Louisville, Kentucky; myself a psychiatric novice, one of a team doing routine examination of the droves of inductees that poured into that camp that summer. The day was sultry and I was tiring from my task. For hours at a stretch, I had been knee-deep in a crude sort of screening, eliciting reflexes, making inquiry as to convulsions, etc. For a brief moment I looked up from my work to catch a breath of air and there my eyes met three distinguished gentlemen standing before me. They wore officers' uniforms which bore no insignia. I soon learned that they were army contract surgeons sent down to help us in our work and that their salary was to be less than that of a first lieutenant, precisely $150.00 per month. I knew they were distinguished but how much so I did not know until they introduced themselves by name. All three were from Chicago: Hugh T. Patrick, George Washington Hall and Peter Bassoe. In my fancied flight they struck me as the Three Musketeers as they marched in with Peter Bassoe bringing up the rear, as was to be expected, much like Athos. I pinched myself to make sure that I was not the victim of genii machinations. At that time, I was yearning for the opportunity of postgraduate work. By his staff meetings at the Chicago State Hospital, Charles F. Read, my first teacher, had succeeded in tilting the lid to bring into view for me the beauteous vistas of psychiatry. Dr. Albert Barrett had succeeded in raising that lid a little further in the short course he gave, at his Psychiatric Institute in Ann Arbor, to the newly inducted young army psychiatrists. The depositing of these three men, Patrick, Hall and Bassoe, in my very lap, struck me as a divine act akin to the dropping of manna from heaven to a distressed people. It is needless to say that I availed myself of the opportunity of this close contact with these three leaders in neurology and I have valued and profited by their friendship ever since.

Dr. Bassoe fostered me as he did many others. I believe his initial interest in me sprang from his sympathy and understanding of the lot of the underdog. Dr. Bassoe's intuitions for the good were infallible. He had that rare faculty of finding the good that is to be found in every individual, even in the worst of us. Just as water seeks its level, Dr. Bassoe's instincts made it possible for him to seep down and ferret out the buried gold in an individual in spite of overlying personality incrustations. Having found it, he always was able to marshall resources to mine that gold and bring it to the surface for further nurture. When I received my discharge from the army, Dr. Bassoe invited me to join his staff at Rush Medical College,

where I remained in close association with him until Rush was merged with the University of Illinois.

Dr. Bassoe was not a distinguished person from the standpoint of sheer physique. He was undeniably short of stature. His distinction sprang from a deeper source. To me, as with many others, Dr. Bassoe always exhibited an aura. The two main foci of this inner glow were his eyes and his smile. His eyes were blue, always as mild as the tarns of his native land. His smile was pleasantly naive. Neither the wrinkles of three score and ten, nor, the pressure of an accumulated worldly knowledge, could eradicate this smile. It was his note of simplicity that was so disarming and which made one so unmindful of one's own inadequacies in his presence. When spoken to, Dr. Bassoe would go through a sort of little song and dance step amounting almost to a mannerism. When asked a question, he would invariably take one step back and then, in a brief moment, step forward to answer the question. During that split second the Bassoe mind had gone into action. He had weighed and balanced everything in the reservoir of his vast experiences. His answer always was a lucid, honest, all-embracing exposition of the problem; often cryptic but of impeccable judgment.

Dr. Bassoe was a teacher of medicine for many years. Although always respected by medical undergraduates, I do not believe he was fully appreciated by them because his teaching was free from pedagogic histrionics often so dear to the hearts of medical students. As a mentor to the older men and to those in this specialty, he was unexcelled as a teacher. The ramifications of his experiences and the rounded out character of his knowledge made him invaluable at the seminar level. His breadth of experience cannot be blamed on book learning or his editorship of the Year Book. There were few neuropsychiatric situations which he had not encountered in his personal experience. Another fact which may have mitigated against him as a teacher to undergraduates was the remnant of an accent which he carried. Dr. Bassoe delighted to tell how the dictaphone machine chopped up his words and brought out his accent almost to a broad brogue.

Time is cruel. No one can tell what it will do in placing his name before posterity. I know of no disease, entity nor syndrome, which will carry Dr. Bassoe's name. If it had been his good fortune to be the discoverer of a specific neurological entity, I am certain that his modesty would have seen to it that it carried a scientific name and not his. He had perfected a technique for the deep injection in tri-facial neuralgia. His technique came to him from the French, via Patrick. Already the necessity for such a procedure has been rendered almost obsolete by the advances of neurosurgery. Nevertheless, it was enthralling to witness him giving these injections. It was the finest synthesis of skill, patience and rapport one could witness. I can readily understand why people flocked to him all over the country for these treatments. His refusal to capitalize financially on this type of case and the modest fees which he charged for this most expert type of service, are just one of the many indications of his total disdain of the commercial side of the practice of neuropsychiatry. This is an attribute seldom found in persons who have been compelled to fight their way up the ladder of success from poverty as did this immigrant lad.

Dr. Bassoe was a prolific contributor to the literature of neurology and psychiatry. His first publication was an article in the "Journal of The American Medical Association," on epidemic meningitis. This was in July 1898, at which time Dr. Bassoe was 24 years old. All in all he contributed close to 100 articles, three of which were published in the year of his death, 1945. His most pretentious scientific contribution was the series of papers on Divers Disease published in 1911. This work was done for the Illinois Commission of Occupational Diseases. My own individual hunch is that permanence to his name may come from his pioneer work on epidemic encephalitis because of his efforts to delineate this as a specific disease and above all he was one of the earliest clinicians to point out the personality disorders as a sequela of this disease. He coined the phrases post-encephalitic, pseudo-moron and pseudo-psychopathia. Dr. Bassoe had a distinct flair for medical oddities and neurological curios. He published a paper on acute malignant pemphigus with an autopsy report; another

one on unilateral hypertrophy involving the entire left side of the body; gigantism and liontiasis ossei with a report of the case of the giant Wilkins; also his paper on the Klippel Feil syndrome. His paper on a case of cervical rib associated with syringomyelia tended to emphasize the aberrant character of both of these conditions and to accentuate the abiotrophic genesis of syringomyelia. A third article, on combined diseases, published in the year of his death, was entitled "The Coincidence of Parkinson's Disease and Cranial Chordoma," which appeared in the February issue of "Diseases of the Nervous System." He helped to organize this Journal and served it in the capacity of associate editor.

Any account of Dr. Bassoe would be incomplete if I did not point out his extreme modesty and his passion for self effacement. The same man who had given his services to his country during the World War I for the modest sum of $150.00 per month and then became a president of the American Neurological Society, offered his services to his country in World War II. This time he volunteered to become an associate attending man in the neurological services of Cook County Hospital when that service was depleted of man power because of the war demands. It was his passion for self-effacement that was the bulwark of the Bassoe strength. People came to him with their problems knowing full well that in helping them to solve them, no consideration would be given to Dr. Bassoe's energies or prestige. He became the confidant of all with increasing crescendo. Thus he was privy to all the underlying cross currents and the clashing ambitions of the personalities around him. He knew how to use the soft pedal, to smooth out all controversies and always seemed to find the right oil to soothe open wounds. Because of these combined qualities, at the time of his death and for sometime before, he had become the repository of the neuropsychiatric conscience of the mid-west.

This man who had risen from the humble position of staff physician in an out-of-the-way mental hospital in Iowa, to make psychiatric history in Illinois, had a career that can be contrasted with that of H. Douglas Singer, who, like him, also came unheralded from a western state to make psychiatric history in Illinois. In many of their efforts, these two great men collaborated. The Illinois Neuropsychiatric Institute is an everlasting monument to Singer's genius and imagination. In the fruition of this dream Bassoe backed Singer to the hilt. Singer's growth and contribution required the implimentation of ego-expansion. Bassoe's growth thrived on ego-contraction. Peter Bassoe had courage and exhibited that courage when he thought that a thing was wrong. As great as his friendship was for Singer, he opposed him in the matter of the Behavior Clinic of the Criminal Court of Cook County. The need for such a clinic to eliminate partisan testimony in the Criminal Court of Cook County was definitely a product of the Singer mind. The idea of the necessity for such a psychiatrically impartial clinic was shared by Dr. Bassoe, but when Singer proposed himself as the clinic's first director, he found himself stymied by Bassoe. Dr. Bassoe in his frank and terse manner opposed Singer's appointment because he did not think Dr. Singer would have the time to devote to this work. Quite an elementary objection, but it was characteristic of the forthrightness of Dr. Bassoe.

Lesser known, but very deep was Dr. Bassoe's interest in court psychiatry. His influence in this field of psychiatry may well prove to be his most tangible and lasting contribution. He wielded great influence by virtue of his position as Chairman of the Court's Committee of the Institute of Medicine of Chicago, a position which he held for many years. This committee sponsored the establishment of the Behavior Clinic of Cook County in 1933, formulating policies and helping select personnel. Since 1929 this committee worked closely with the Psychiatric Institute of the Municipal Court. Dr. Bassoe had a keen appreciation of the pioneer work in Chicago in forensic psychiatry. He was mindful of the contributions to the Chicago scene and to the country at large by William Healy, Herman Adler, W. J. Hickson and Meyer Solomon.

He had a distinct distaste for partisan psychiatry or court appearances. He abhorred the battle of the alienists and hired psychiatric testimony. He fostered the Criminal Court Behavior Clinic to combat this evil. On the

rare occasions that he appeared in court he preferred to testify with complete objectivity as a "friend of the court;" a status he wished for all psychiatrists. He always stressed the preventative role that psychiatry could play in a court-room, viewing the matter in a very pragmatic manner. Of the Municipal Court Clinic, he wrote, "that it has saved much time for the courts and much money for the taxpayer."

Dr. Bassoe's mind was a resilient one. He was not a die-hard or a stand-patter either in his personal or professional life. He considered psychoanalysis the caviar of medicine, much too rich for his simple digestion. At that he tried to cultivate a taste for it by converting himself to a student to sit on the bench and listen to the most elementary courses in psychoanalysis. In spite of this distaste, he was one of the first men in the Chicago area to give the analysts an opportunity to exhibit their skills in psychosomatic situations. He opened both the facilities of the Rush Medical College and the Central Free Dispensary to them. Although he probably would never accept the term of positive transference as used by the psychoanalysts as bonafide, his own personality lent itself to this mechanism in the doctor-patient relationship more readily than any other individual that I have ever known.

The resiliency of his mind needs no better proof than the fact that his last paper which appeared in the May issue of "The American Journal of Psychiatry," namely, "Spain as the Cradle of Psychiatry," was a far fling from his earlier organic neurological contributions. This paper was undoubtedly an outgrowth of his interest in the last decade of his life in the study of Spanish. This was stimulated by his vacations spent in Mexico and his desire to bring about a better understanding between neuropsychiatrists above and below the Rio Grande. Anyone who was privileged to hear Dr. Bassoe deliver this paper before publication at the Illinois Neuropsychiatric Society, when he was already in the throes of the physical ailment which led to his death, will long remember the event both because of the efforts put into his prepared paper and particularly because of his off-the-record asides. That night he exuded with Bassoe charm.

Dr. Bassoe had a strong impulse to give everyone his due. When the American Psychiatric Society was scheduled to meet in Chicago in May of 1945, he was asked to prepare an article on the activities in Chicago. This article is to be found in the March issue in the "Journal of American Psychiatry" and is entitled "Psychiatric Facilities of Chicago and Its Surroundings." The meticulousness with which he prepared this article together with his obvious effort to give public recognition to every psychiatric workshop in Chicago, no matter how small, was characteristic of him.

If the adage that a man can be judged by his enemies is to be invoked in the case of Dr. Bassoe, no judgment would be possible. Many people die beloved, few unhated. It can be said that Peter Bassoe died without a single enemy. If it were my privilege to write his epitaph, I would inscribe these simple words, "Here lies Peter, a princely plebian." Princely in the true Goethian sense of the word, he was possessed of an insatiable thirst for knowledge which led him into heights of rare erudition. His fidelity to just causes and good men about him led him to a position of leadership in the worthwhile reforms. His innate magnanimity caused him to be charitable to the weaknesses and idiosyncrasies of his fellow-worker. Plebian in the best sense of that word, having "walked with Kings" he never "lost the common touch." Perhaps the most succinct tribute to him can be found in the words of his protege, Dr. Harry R. Hoffman, the present State Alienist of Illinois, who always affectionately spoke of Dr. Bassoe as being "as common as an old shoe."

Perhaps neurological immortality will be denied him. There is no doubt that he had earned for himself a definite position in the lore of American neurology. He lived in an era which produced such men as Bernard Sachs, Singer, Jelliffe, Spiller and Patrick, amongst others. In fact he may be regarded as "The Last of the Mohicans" of this period. He helped to mold that era which traditionally will be labelled as The Romantic or Mauve Period of American Neurology.

As for myself, I thank my lucky stars that I was privileged to walk part of the way with this fine human being, however haltingly.

1121 South State Street.

Neurological Clinical Pathological Conference

of the

Cincinnati General Hospital

CHARLES D. ARING, M.D., *Editor*

Case No. 123636

PRESENTATION

A 24 year old white, married woman, a waitress, was admitted to the Neurological Service on July 1. Six months previously there had been an onset of bouts of headache associated with vomiting. The headache would come on suddenly two or three times weekly, and sometimes daily, and was always in the left fronto-parietal region. These headaches appeared unexpectedly, day or night, and lasted from a few minutes to a few hours; they were throbbing and were associated with nausea and vomiting, and blurred vision. The headache had become more intense during the later weeks of the present illness.

As the headaches became worse they were usually but not always accompanied by loss of consciousness, resembling fainting; later in the course of the illness these episodes assumed the character of a fit. The disturbances of consciousness were not always complete and sometimes lasted for minutes. Muscle twitching of varying distribution usually occurred following which she was very groggy and unable to speak, though she was aware of happenings about her.

Some attacks were said to begin with twitching on the right side of the face or of the tongue, or in the right hand, and then become generalized. In these she would bite her tongue, but not lose sphincter control, and she would remain unconscious from 30 minutes to one hour. All attacks were followed by extreme lethargy and fatigue.

Between attacks she felt relatively well. There was a story of epigastric distress for six months described as sharp pain accompanying the nausea and vomiting. She had vomited almost daily; this had reduced her food intake and she had lost 12 pounds. For ten weeks before hospital entry she had been on an ulcer diet under the supervision of a physician.

Three to five months before admission there had occurred blurring and dimness of vision, photophobia, and diplopia, noticed on changing from the sitting or reclining position to the upright. These symptoms progressed to relative or complete blindness. Improvement then began to occur; over a period of several weeks vision was said to have been restored to normal.

From the age of 3 until 14 years when they disappeared, she had had headaches, the description of which resembled migraine (periodic headache, visual blurring, nausea, and vomiting). Five years before the final illness she had been shot and the bullet traversed the diameter of the left chest, but she recovered without incident. She had typhoid fever two years before the final illness and in the previous year she received a blow to the left frontal region in an automobile accident. She was stunned but not unconscious and was weak and dizzy for three days.

She had been married for nine months to a bartender, 16 years her senior. She had had no pregnancies or miscarriages. There was a negative history of venereal disease or exposure to infections.

At the admission examination on July 1, she was quite thin, weighing 82 pounds. There was epigastric tenderness and a profuse, thick, white discharge from the cervix. Abnormal neurological signs were papilledema and an extensor response on the left and a tendency toward an extensor response on the right. A fit was observed in the hospital; it lasted about a minute. The head turned to the right there occurred circumoral twitching, some clonic movement of the right upper extremity, and the right pupil became dilated and fixed. There was amnesia for the attack which was followed by right facial weakness.

On July 4 some tenderness and slight irregularity of the left frontal area of the skull was noted, the right pupil was slightly larger than the left, there was mild right facial weakness, papilledema of 2 to 3 diopters, a strong extensor plantar response on the left,

and a suggestive extensor response on the right. On other occasions either a flexor response or no response at all was obtained on the right.

She vomited daily and complained of nausea and severe frontal headache frequently. Sometimes she had excruciating pain in the frontal region for 15 to 30 seconds and with its subsidence she felt quite well. At other times the pain was prolonged for hours. On July 6 she was unable to urinate.

On July 8 attempts at ventriculography (right and left) were unsuccessful, and the injection of 40 cc. of air into the lumbar subarachnoid space did not visualize the ventricles. While draping the head preparatory to a craniotomy the systolic blood pressure fell from 110 to 70 mm. Despite heroic supportive therapy, the patient expired on the operating table on the eighth hospital day.

Laboratory Data: The pulse rate ranged between 56 and 76; most frequently it was clocked between 60 and 62. The systolic blood pressure before entering the operating room ranged between 98 and 104 mm., the diastolic pressure between 60 and 70 mm. Blood counts, urinalyses, and sputum examinations were normal. Roentgen examination of the skull was normal. A blood Wassermann was very strongly positive. Examination of the visual fields and acuity were normal. Spinal tap was not done because of the papilledema.

DIFFERENTIAL DIAGNOSIS

Dr. Howard D. McIntyre: If you allow the facts to lead you where they will, you have a beautiful case for brain tumor. The story and signs are classically those of brain tumor. However, that seems a little too easy for a conference of this sort.

Analyzing the symptoms, there were headache, vomiting, choked discs, and pain in the left fronto-parietal region. The pain was not steady but was rather neuralgic in character. Another point difficult to explain is the transient visual attacks and the bout of blindness; later it is said the visual fields were normal. I am at a loss to explain the attack of amblyopia with recovery.

The first complaint was headache. The second complaint was characteristic of a firing point in the left frontal lobe; Jacksonian fits began in the face or in the right hand and spread. This is additional evidence for neoplasm.

The stomach symptoms are interesting; possibly they might be an accompaniment of syphilis. Most likely they are the result of prolonged vomiting.

In the past history we find migraine; the attacks consisted of headache, blurring of vision, nausea and vomiting. Were the fulminating headaches of the present illness migraineous in character? I don't think so, even though they were limited to one side of the head and were associated with visual disturbance.

I have seen three cases of migraine, in which eventually the migraine was associated with tumor. The usual pattern is illustrated by the story of one young man whose migraine occurred regularly once a month with headache and vomiting. His mother and father both had migraine with hemianopic phenomena. This man stopped having migraine when he developed an illness which finally turned out to be tumor in the right temporal lobe and he never had another attack of migraine. The migraine ceased after the tumor symptoms began.

Another point in the history is the bullet wound in the left chest which would suggest a chronic lung abscess with metastatic abscess in the brain. This is quite far-fetched and I dismiss it promptly. The blow on the head brings up the question of subdural hematoma.

So the neurological examination with bilateral choked discs, headache, and vomiting would suggest tumor. The larger right pupil is difficult to explain on my left frontal lobe localization. With acute increased intracranial pressure in tumor or hemorrhage the pupil on side of the lesion may be dilated. Since the contralateral pupil is dilated, bilateral involvement of the frontal lobes is suggested. Another point in favor of bilateral frontal lobe lesions is that the pyramidal tract signs were more prominent on the left than on the right. This brings in the question of Kernohan's notch of the brain stem where tumors of the hemisphere drive the stem against the tentorium of the opposite side, which may produce pyramidal tract signs on the same side as the lesion. Whether that is the factor here, I wouldn't know.

The failure of the ventriculography may

mean one of two things. If it were done by an expert I would assume that the ventricles were compressed and of about the same size. In unilateral tumor there usually is unilateral hydrocephalus and it is not too difficult to find one of the ventricles at least. This point would seem to rule out the possibility of large unilateral hydrocephalus.

In the differential diagnosis one certainly has to consider something that is connected with syphilis, although one may be misled by the positive Wassermann reaction. But I am going to try to stick to facts and therefore consider gumma in this case. Cerebral gumma is rarely diagnosed before the pathologist recognizes it. In Cushing series of 2000 cases, only 0.3 per cent were gummas.

Another possibility in considering syphilis is Heubner's entarteritis with consecutive softening of the brain. And finally adhesive syphilitic arachnoiditis may block the cerebrospinal fluid circulation and produce increased intracranial pressure. Focal meningovascular involvement would help to explain multiplicity of symptoms, particularly the firing point in the left frontal lobe.

Subdural hematoma is to be considered and I don't know how you can rule it out since we know nothing about the spinal fluid. The interval between trauma and symptoms is a bit long; I think the longest interval I have seen has been six months. There have been cases reported with considerably longer intervals.

Glioma must be considered and perhaps the positive blood Wassermann is just to make the case difficult. Brain abscess from the old chest injury I would dismiss. I might also eliminate tuberculoma with the aid of the sputum examination.

DISCUSSION OF PATHOLOGY

Dr. I. Mark Scheinker: On gross examination the brain was distended; the gyri were flattened and broadened. An uncal herniation measured in width 1 cm. on the left and 7 mm. on the right. The leptomeninges at the base were slightly thickened.

Coronal sections of 1.5 cm. thickness were made through the hemispheres. There was a yellowish translucent, almost circular lesion, measuring 1.5 cm. in diameter involving the gray and white matter of the third frontal convolution on the left. The center of the lesion appeared as a core compared to the periphery. The white matter of the entire left hemisphere showed signs of far advanced swelling associated with compression of the lateral ventricle. On the right in the depths of the Sylvian fissure involving gray and white matter there was a similar lesion measuring 1.3 cm. in diameter. The white matter of the right frontal lobe was swollen. Both lateral and the third ventricles were strikingly compressed; there was no shift of the midline. The compression was due to the extreme swelling of the white matter of both hemispheres. The remaining portions of the brain were normal.

The microscopic examination of sections taken from both frontal lobe revealed focal areas of necrosis surrounded by a very cellular granulation tissue. The latter was composed of epitheloid cells, lymphocytes, fibroblasts, and macrophages. In addition there were numerous small granulomas diffusely scattered throughout the white matter. The leptomeninges were distended and harbored lymphocytes and plasma cells, especially pronounced in sections taken from the optic chiasm. Some of the pial blood vessels showed tremendous proliferation of the intima with secondary narrowing or obliteration of the vascular lumen; the adventitia was infiltrated with lymphocytes.

In preparations stained with silver (Bodian) the central necrotic core of the frontal lobe lesions showed mesenchymal fibers and fibroblasts. There was far advanced swelling of the white matter of both frontal lobes.

The association of granulomatous lesions with vascular alterations typical of Heubner's syphilitic endarteritis and the basilar leptomeningitis; the network of connective tissue fibers within the central necrotic core of the granulomatous lesions make the diagnosis of multiple gummas of the brain. The only other organ similarly affected was the spleen.

Before the period of the modern treatment of syphilis, gummas of the brain were not an uncommon postmortem finding. At present, however, they are extremely rare. Courville[1] who surveyed 15,000 autopsies found gummas in only six cases; three of them were localized in the frontal lobes. The pre-

sented case is the single one in our Laboratory in eight years.

It is of interest to note that at an earlier date in the history of intracranial surgery, it was the practice to treat all cases as luetic before submitting them to surgery. At the present time no one would think of such a procedure. We know now that gumma is not only the rarest form of neuro-syphilis but it is also one of the rarest types of cerebral tumor.

Doctor McIntyre's Diagnosis:

Bilateral gumma, frontal lobes.
Meningovascular syphilis (Heubner's endarteritis with consecutive softening of the brain).

Clinical Diagnosis:

Left frontal lobe tumor, probably astrocytoma.

Anatomical Diagnosis:

Bilateral gumma, frontal lobes.
Gumma of spleen.
Meningovascular syphilis.

Dr. Charles D. Aring: There isn't much to add to the expositions of Doctors McIntyre and Scheinker. Doctor McIntyre made the point I wanted to make by the selection of this case. The accurate analysis of the cerebrospinal fluid is of extreme importance in neurological practice; probably it is next in importance to the history.

What occurred in this case has come within my observation about one-half dozen times in the various institutions with which I have been associated. It seems, in my experience at least, that it is more dangerous not to do a lumbar puncture than it is to do one. It is my personal belief that one can nearly always get by with a carefully done lumbar puncture when it is of critical import to have the information lent by the cerebrospinal fluid.

I think it is good routine practice not to do a lumbar puncture when the discs are choked. One may cause the medulla to descend and impinge on the boney foramen magnum, thereby being directly responsible for death. I have been told by persons who have in this manner produced death, that once it happens to you, you lose some of your inquisitiveness about the cerebrospinal fluid in persons with papilledema.

In the circumstances mentioned it seems that one could use a very fine needle, for example a 22 gauge Pitkin, and remove a small amount of fluid, possibly enough for cell count, quantitative protein determination, and the Wassermann examination—and leave behind a very tiny hole which would limit subsequent leakage.

As to the Clinical Pathological Conference technique, I think it requires that anything not mentioned in the protocol is to be considered as normal. In this case we should have mentioned that the ventricular fluid was not analyzed.

About the pupils in intracerebral lesions. In our studies[2] of stroke the contralateral pupil was dilated in 22 per cent of cases of proven intracerebral hemorrhage.

Dr. McIntyre: Do you think the choked discs and increased intracranial pressure could have been contributed to by luetic meningitis? I don't understand the episode of blindness, and later the normal visual fields.

Dr. Scheinker: There wasn't very much meningitis. That at the base was of moderate degree and wouldn't seem responsible for the choked discs and signs of increased intracranial pressure. On the other hand there was a tremendous degree of swelling secondary to the gumma, which could probably explain the increased intracranial pressure.

REFERENCES

1 Courville, C. B.: "Pathology of the Central Nervous System," Portland, Oregon, *Pacific Press Publishing Association*, 1937, p. 150.
2 Merritt, H. H., and Aring, C. D.: "The differential diagnosis of cerebral vascular lesions," *Proc. Assn. Res. Nerv. and Ment. Dis.*, 1937, 18: 682-695.

Psychiatric Aspects of Head Injury*

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The psychiatric problems following head trauma may be classified as follows:

1. Organic psychotic reactions.
2. Post-concussion syndromes.
3. Functional emotional disorders.
   a. Traumatic neuroses and psychoses.
   b. Malingering.

Organic Psychotic Reactions

Although transient mental reactions such as deliria occur commonly immediately following recovery of consciousness, serious permanent psychoses are uncommon. Only 0.6 per cent of annual admissions of patients to mental hospitals are for head trauma. Less severe disturbances of mental faculties such as memory impairment and changes in personality, not sufficient to require institutional treatment, are much more frequent and can be expected in a fairly high percentage of older patients. The lay public tend to overemphasize head injuries as a cause of mental disorders and epilepsy.

The criteria for establishing a diagnosis of post-traumatic organic dementia are: a definitely severe head trauma without other preceding factors such as infection; a psychosis developing shortly after the head injury; true signs of intellectual disturbance; and confirmatory electroencephalographic and pneumoencephalographic findings of cortical damage. Such conditions as dementia precox, paranoidal states or general paralysis following head trauma, are not true traumatic psychoses. Psychogenic symptoms also frequently will be superimposed upon a true organic syndrome, but the mere presence of psychogenic symptoms does not disprove the organic basis. An element of malingering or simulation may also accompany true organic states.

Alcoholism plays an important part in the production of traumatic psychoses. The acute or chronic alcoholic is particularly likely to suffer cerebral injury.

Pathogenesis:

Skull fracture is not always present. The major lesion may be on the surface of the brain, as in subdural or epidural hemorrhage. Probably the most important lesion (aside from the general effects) is cortical atrophy secondary to multiple punctate hemorrhages, —a true traumatic encephalitis. The most extensive pathology occurs in the frontal areas.

Symptomatology:

The mental symptoms are the same as those found in any organic dementia caused by toxic states, infectious or degenerative diseases.

Acute types: Simple concussion syndrome is characterized by light forms of confusion, slight disorientation, emotional changes and lack of insight, usually with speedy recovery. The more severe types may persist for weeks or months. The first stage is coma and then delirium, followed by amnesic or Korsakoff stage. The latter is characterized by disorientation of time and place, markedly impaired recent memory, confabulation, retrograde amnesia and poor perception despite the presence of clear consciousness and good remote memory. There may or may not be focal neurologic cranial nerve or tract signs present. The emotional reactions are often euphoric. A facetious mood changes quickly to sullen, irritable, suspicious reactions. The patient lacks insight and denies ever having been injured.

Prognosis:

Prognoses are not easy to make. The shorter the period of initial unconsciousness, the better the prognosis. Complicating organic factors as alcoholism or arteriosclerosis make the outlook more grave. Children recover better than adults. Traumatic epilepsy develops within two years in perhaps 10 per cent of cases.

*Given as a part of a symposium, Omaha Midwest Clinical Society, October 25, 1945.

Post-Concussion Syndrome, Personality Disorders

The post-concussion syndrome is one of the most perplexing problems of medicine. There are no well defined criteria to evaluate the role of head injury in the causation of the patient's symptoms. Headache, dizziness, asthenia, inability to concentrate, sleep disturbance, etc., are commonly present after head injuries and are called post-concussion symptoms. When they persist for months they are labelled post-concussion syndrome. Whether they are of psychogenic or physiogenic origin is the subject of much controversy. Assessment of previous psychoneurotic constitution and compensation factors may aid in proper evaluation. The presence of any organic neurologic signs, electroencephalographic or x-ray evidence of cortical damage, confirms an organic diagnosis.

Functional Emotional Disorders

a. Traumatic neuroses and psychoses:

These psychogenic reactions following head trauma are usually seen after a minor head injury, with little or no loss of consciousness and no x-ray evidence of trauma. The emotional reaction set off by the accident, usually a fear state, starts the symptoms. The reaction that follows is either an hysterical or anxiety neurosis, often wth progressive severe depressive symptoms. At times a paranoidal state of psychotic type developes. The term traumatic neurosis is objectionable just as is shell shock, because it implies an organic injury. We use the term to mean that the traumatic factor is causative, without any previous evidence of predisposition for neurosis to start the emotional illness.

Psychopathology:

The incidents occurring at the time of the accident are important etiologically. A narrow escape from death or the patient's notion that he narrowly escaped may set off an acute panic of fear. Events soon after the accident may suggest serious injury or hysterical symptoms to the patient. Transportation to the hospital by ambulance, examinations by the doctor and calls by a lawyer all have suggestive effects upon the sensitive patient. If the patient suffering from functional emotional symptoms is treated as an organic case then he may develop fixed ideas of invalidism and honestly believe he is disabled. Or the patient then may see an opportunity for much needed financial reward. This factor influences his behavior consciously as malingering or unconsciously as an hysterical reaction, with greatly exaggerated symptoms as a result. Repeated examinations and prolonged litigation, with overemphasis by lawyers, contribute suggestive factors and encourage persistent neurotic invalid reactions.

Symptomatology:

A multitude of subjective complaints without objective evidence is the rule. Functional neurologic signs—anesthesias, palsies, bizarre postures and gaits, etc.—may be present as conversion hysterical findings.

Irritability, anxiety with accompanying physical reactions such as cardiac, vasomotor or gastrointestinal disfunction, fearful attitude toward recovery and dislike of recalling the accident all characterize the anxiety state. Other patients may show deeper depression, with loss of interest in life, insomnia, fearful dreams and even suicidal desires that may be more truly a reactive depressive psychosis than a neurosis. Extreme concern about self and definite hypochondriacal ideas are common to both anxiety and depressed states.

Prognosis:

It is my opinion that the prognosis generally would be much better if these cases were recognized immediately as neuroses and given early appropriate psychotherapy. Unfortunately, in the majority of cases a true diagnosis is not made before extensive examinations, including x-rays, and litigation have been had. The golden opportunity for therapy has been missed, just as cases of war neurosis grow steadily worse the farther they are evacuated from battle to the rear, and the later treatment is begun. The emotional reactions become fixed and treatment is usually ineffectual unless monetary remuneration to the patient's satisfaction is made. But if appropriate psychiatric treatment is begun early, recovery should be the rule. Previous

psychoneurotic tendencies and complicating organic diseases make the prognosis poorer.

b. Malingering or Simulation:

The motives for malingering are strong when large sums are paid by insurance companies to settle personal injury claims. Unquestionably many frauds are systematically perpetrated by certain individuals. We frequently learn of individuals who have received settlements for minor or questionable injuries. These cases cause claim agents to distrust all psychic states and to consider them as malingerers. At times it is hard to differentiate a true neurosis from malingering. Very often the condition is mixed. Feigning organic neurologic conditions is practically impossible since functional disturbances in sensation and paralyses are easily detected. When a patient complains of pain, vertigo, changes in personality or other subjective ills without objective evidence, it is not easy to decide whether the patient is truthful or not.

In differentiating such cases the tool of electroencephalography will become increasingly useful. Strong evidence of desire for financial reward rather than desire for recovery makes one suspect an element of malingering. The malingerer shows a decidedly antagonistic reaction toward the examination, often accuses the physician of working solely for the insurance company, dislikes to give facts of history, etc. The neurotic, however, is more eager to cooperate and impress the examiner with the seriousness of his illness. Sometimes the proof for malingering can be obtained only from external data concerning the behavior of the patient when not observed by a physician. Taking motion pictures or observing the patient's activities by lay witnesses when he is living normally are often the only way to prove malingering.

Electroencephalography:

Alterations of the electrical activity of the cerebral cortex are fairly constant and occur in a high percentage of true organic postconcussions and in more severe types of head injuries. In the acute stages random delta waves occur and disorganization of the alpha rhythm and epileptiform discharges also occur. With recovery from the injury these gradually return to normal except when there has been localized injury to the cortex or a hematoma is present or the record was abnormal before the injury. In general, the degree of abnormality corresponds closely with the severity of injury and clinical improvement parallels the improvement in the E.E.G. Probably the greatest value aside from localization is in the differentiation of posttraumatic syndromes of organic type from malingering or hysteria. An abnormal record favors an organic diagnosis, but we must remember that 15 per cent of so-called normals have abnormal records. A normal record taken within a few weeks after a head injury is good evidence the symptoms are functional.

Treatment and Rehabilitation:

A most important aspect of treatment is the prevention of later sequelae by proper medical and surgical treatment immediately following injury. This means not only management of the trauma but also proper handling of the examination and especially the psychologic treatment, if no severe injury has been sustained. Certain specific measures, such as management of acute intracranial pressure and surgical conditions prevent late sequelae.

In the early psychotic states, particularly delirium, it is often a question as to whether cerebral edema or dehydration is the factor to be treated. Nutritional measures and at times certain vitamins are indicated, particularly if alcoholic complications exist. Sedation should be used very cautiously if at all, and then only those drugs which do not induce cerebral pressure decompensation, e.g., paraldehyde. Morphine and barbiturates are contraindicated. If subarachnoid hemorrhage is present spinal drainage is often the best sedative treatment.

After the acute stages, with medical and surgical complications taken care of, the psychiatric treatment usually involves treating the residual personality problem and general convalescence of the patient. Rehabilitation should start as soon as the patient has recovered from the acute effects of the injury. Much can be done to prevent chronic invalidism by intelligent psychologic treatment during the early stage as well as later in the course of recovery.

The prevention of traumatic neurosis should

be a prime objective. The physician who first sees the patient should not hospitalize him for a minor injury. He will thus avoid suggesting a serious injury when none exists. The emphasis should be shifted from compensation to rehabilitation.

The post-traumatic syndrome, probably organic but influenced by emotional and psychoneurotic factors, must be recognized early and given special treatment. There is rarely any reason why the patient should not be allowed to get up within a few days after regaining consciousness. Graduated physical exercises should begin as soon as the patient is able to be out of bed, to reestablish postural relationships. The purpose is to prepare him to adjust himself to the physical demands of his normal life. Gradually increasing activities, with at first light activity, occupational therapy, mental exercises and later heavier tasks directed toward full restoration of physical-mental capacity should be the goal. Neurologic handicaps must be treated individually as indicated. The emphasis should be placed upon early activity rather than prolonged rest in bed. As yet, medical therapy for the relief of post-traumatic headaches and dizziness has not proved to be helpful. Sometimes complete spinal drainage and air replacement have relieved post-traumatic headaches. In certain cases permanent residual handicaps will have to be admitted and the patient's general routine and life adjustments planned according to his needs.

In the few organic psychotic reactions with permanent dementia, custodial care will have to be provided either at home or within an institution, according to the degree of behavior maladjustment present.

Newsnotes

WINFRED OVERHOLSER, M.D., HEADS NEW PUBLICATION

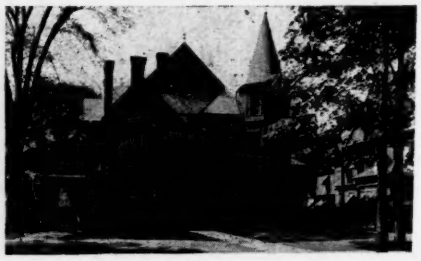
Announcement of a new publication, "The Quarterly Review of Psychiatry and Neurology," with Winfred Overholser, M. D., as editor-in-chief, has been made by the Washington Institute of Medicine, Washington, D. C., which will publish it. It will be brought out in January, April, July and October, at an annual subscription rate of $9.00. Members of the editorial board are Spafford Ackerly, M.D., A. E. Bennett, M.D., Karl M. Bowman, M.D., Stanley Cobb, M.D., Frederic A. Gibbs, M.D., Edward J. Humphreys, M.D., Solomon Katzenelbogen, M.D., J. M. Nielson, M.D., Lewis J. Pollock, M.D., Tracy J. Putnam, M.D., Lauren H. Smith, M.D., and John C. Whitehorn, M.D.

LABORATORY FOR NEUROPSYCHIATRIC RESEARCH

The Sinai Hospital of Baltimore, Maryland, has announced the establishment of the Alfred Ullman Laboratory for Neuropsychiatric Research. The work in the laboratory will be carried on under the direction of Dr. H. S. Rubinstein.

AMERICAN PSYCHIATRIC ASSOCIATION MEETING

The Annual Meeting of the American Psychiatric Association will be held at the Palmer House, Chicago, Illinois, May 27-30, 1946. For reservations and other information in regard to the meeting communicate with Mr. Austin M. Davies, Executive Assistant, 9 Rockefeller Plaza, New York 20, New York.



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